Health Insurance Mediation Authorization Form

Texas Department of Insurance

Complete the form and mail, fax, or email it to

Texas Department of Insurance
Consumer Protection Program (MC 111-1A)
P.O. Box 149091
Austin, TX 78714-9091
Fax: 512-475-1771
E-mail: ConsumerProtection@tdi.texas.gov

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION OR OTHER CONFIDENTIAL INFORMATION

I authorize the Texas Department of Insurance to disclose my protected health information or confidential information to my health benefit plan, (name of health benefit plan_____), the mediator appointed by the State Office of Administrative Hearings, and the State Office of Administrative Hearings, for the purpose of mediating my claim under the requirements of the Insurance Code Chapter 1467. The information I authorize TDI to disclose may include mental health records, excluding psychotherapy notes, genetic information, including genetic test results, drug, alcohol, or substance abuse records, and HIV/AIDS Test Results/Treatment. TDI may disclose all of the information I have provided with the Health Insurance Mediation Request Form.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; withdrawal of permission; or completion of mediation.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the Texas Department of Insurance. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information or other confidential information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information or other confidential information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

SIGNATURE
X_____
Signature of Individual or Individual's Legally Authorized Representative DATE
Printed Name of Legally Authorized Representative (if applicable):
_____
If representative, specify relationship to the individual: ¨ Parent of minor ¨ Guardian ¨ Other
_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE
X_____
_____
Signature of Minor Individual DATE